

FILED MAY 27 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17368

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>1077</u>	
1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u> b. CITY OR TOWN <u>APFTON</u> c. LENGTH OF STAY (in this place) <u>2 Yr. 3 Mo</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MILLER NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u> c. CITY OR TOWN <u>APFTON</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>8149 GRAVOIS</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>BARBARA</u> b. (Middle) <u>SCHNEIDER</u> c. (Last) <u>SCHNEIDER</u>				4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>		8. DATE OF BIRTH <u>Nov. 10 1876</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIDOW</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		10. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
12a. FATHER'S NAME <u>CHARLES DIETRICH</u>		12b. MOTHER'S MAIDEN NAME <u>AMELIA KUNKEL</u>		13. NAME OF HUSBAND OR TYPE <u>WILLIAM SCHNEIDER DEC'D</u>			
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		15. SOCIAL SECURITY NO. <u>492-03-17100</u>		16. INFORMANT'S SIGNATURE OR NAME <u>William H. Roberts</u> ADDRESS <u>3294A Harris</u>			
17. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Aortic Stenosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> ANTECEDENT CAUSES DUE TO (b) <u>Chronic Nephritis</u> <u>1 year</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> <u>1 yr.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. HOW DID INJURY OCCUR? <u>#146K</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>Feb. 14, 1955</u> , to <u>May 11, 1955</u> , that I last saw the deceased alive on <u>May 10th 1955</u> and that death occurred at <u>9:00 a. m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>W. H. Roberts</u> (Degree or title)				23b. ADDRESS <u>3608 S. Grand Blvd.</u>		23c. DATE SIGNED <u>5/12/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>MAY 13 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>	
DATE REC'D BY LOCAL REG. <u>5/12/55</u>		REGISTRAR'S SIGNATURE <u>Kurtz R. Donke, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Kute 2906 Harris</u> ADDRESS			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

He 1-0766  
36085 Grand.  
Pn 2-7891

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Leo J. Budd*  
Licensed Embalmer No. *379*  
P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.